CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2712
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR LICENSURE AS AN ADVANCED PRACTICE NURSE
INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failure to follow instructions may result in a delay of licensure.

When to File APN Application

- You must be concurrently applying for or already hold an active Registered Nurse license either in Delaware or one of these *compact states*.
  Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin

  Note: For important information on how the Nurse Compact affects your Nursing license, see *Compact (Multi-State) Licensure* on the Board's website at www.dpr.delaware.gov.

- You must have a:
  - Master's degree, or
  - Post-basic program certificate in a clinical nursing specialty with nursing certification from a national certification body recognized by the Board, if certification is available.

- The practice requirement that you must meet depends on whether national certification is available for your specialty.

IF national certification is…	**THEN you must meet one of these requirements…**
available	• Practice of 1500 hours over the past five years in the specialty for which you are applying, or • Practice of 600 hours over the past two years in the specialty for which you are applying, or • Graduation from the specialty program within the past two years.
not available	• Practice of 1000 hours over the past two years in the specialty for which you are applying, or • Completion of a period of at least 1000 hours of supervised practice. Contact the Board office.

- To practice in Delaware, APN's are required to have a collaborative agreement (Section 8.4 of the Board's Rules and Regulations). You may apply for an APN license without a collaborative agreement. However, do not start *practicing* as an APN in Delaware until you have a collaborative agreement and your APN license or a temporary permit has been issued.

- If you wish to be licensed to practice more than one APN specialty, you must file a separate application for each specialty.

- If your application is not complete within six months of filing, it may be considered abandoned and discarded. The Board office will notify you before disposing of an abandoned application.

- When your APN license is issued, it will have the same expiration date and come up for renewal at the same time as your Delaware RN license.

How to File APN Application

☐ **Unless you are applying for a Delaware RN *at the same time*, complete the *Authorization for Release of Information* form to request a criminal background check. Follow the instructions on the authorization form to arrange to be fingerprinted.** You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Submit completed, signed and notarized application form.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.
- Forms that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."
- The fee for initial license is $97.
- The fee for reinstatement is $146.
- Applications submitted without this processing fee will be rejected.

☐ Unless you are applying for a Delaware RN *at the same time*, enclose a copy of your driver's license or official identification card from the Division of Motor Vehicles.

☐ Request your APN program to send an official transcript *directly* to the Board office.

☐ If your specialty requires national certification, enclose a copy of your original certification notice or current re-certification card with your application ***and*** submit proof of national certification as shown in this table.

IF you are…	**THEN enclose copy of certification notice/card <u>and</u>…**
CRNA	The Board office will verify your certification online.
Neonatal NP	Complete online verification request on www.nccwebsite.org.
Any other specialty	Complete the applicant section of the *Verification of National Certification* form. Send it to the organization that issued your national certification. • There may be a fee. • After completing the form, the organization must return the form *directly* to the Board office. Forms received from you will be rejected.

☐ If you have a collaborative agreement, your collaborator must sign where indicated in the COLLABORATIVE AGREEMENT section.

How to Apply for a Temporary APN Permit

A Temporary APN Permit allows you to practice as an APN until your license is issued.

- *Delaware temporary permits are not valid for work in any other state.*
- A temporary permit does <u>not</u> give you prescriptive authority!
- You must be supervised while working under a temporary permit.
- **Do <u>not</u> begin employment until you are assigned a temporary permit number**.

Applying for a Temporary APN Permit (continued)

All of the following are required for issuance of a temporary permit:

☐ "Yes" to the question about temporary permit.

☐ Temporary permit fee of $32.00 by check or money order made payable to "State of Delaware."
- This fee is *in addition to* the processing fee for the application.

☐ Official copy of your transcript to be sent *directly* from your program to the Board office.

☐ *If your specialty requires certification*, copy of your original certification document or current re-certification card.
- If you are not yet certified, request the certifying organization to submit a letter verifying your eligibility to take the examination.
- If you fail the examination, your Temporary Permit will be terminated. Submit a request to the Board to work under supervision until you pass the examination and receive your certification. Your supervisor must submit a letter that he/she will supervise you until you pass the examination and receive your certification.

☐ *If certification is not available for your specialty and you do not have 1000 hours practice in your specialty over the past two years*, letter from your supervisor agreeing to supervise you and to report when you have completed the 1000 hours practice.

☐ Results of the criminal background check.

Your permit will be issued within seven days of the date all of the above documentation is received. It will be mailed to you and is not available at the Board office. Meanwhile, you may verify your permit online at dpr.delaware.gov. Click on "Verify License Online." The temporary permit expires 90 days from issuance.

How to Apply for Prescriptive Authority

The *APN Application* includes a question asking whether you are applying for prescriptive authority.

- *You must have a collaborative agreement to apply for prescriptive authority.*
- You may apply for prescriptive authority at the same time as you apply for APN licensure or later on.
- You must have prescriptive authority before you can apply for a controlled substance registration.
- If you receive prescriptive authority, you may prescribe only non-controlled substances. To prescribe controlled substances, you must first file an application for a Delaware controlled substance registration. See *Controlled Substances* on www.dpr.delaware.gov. After your Delaware controlled substance registration is approved, you then file for a federal DEA registration.

To apply for prescriptive authority at the same time as your APN license…

☐ Answer "yes" to the question about prescriptive authority.
- There is no additional fee to apply for prescriptive authority.

☐ Complete the COLLABORATIVE AGREEMENT section. Have your collaborator sign the collaborator certification.

How to Apply for Prescriptive Authority (continued)

☐ The official transcript from your APN program that you submitted for APN licensure must ***clearly*** show that you have completed academic courses in all of the following:

- advanced health assessment
- diagnosis & management of problems within your clinical specialty
- advanced pathophysiology
- advanced pharmacology/pharmacotherapeutics

If it doesn't ***clearly*** show this coursework, the Board office will contact you for further documentation.

☐ This table shows when proof of continuing education (CE) ***in advanced pharmacology and pharmacotherapeutics*** is required.

IF you completed your APN program…	**THEN…**
within the past two years	You do not need to submit any proof of CE.
over two years before this application and you hold a current, valid APN license with prescriptive authority in another state	Submit: • Copy of your APN license that is ***clearly*** marked prescriptive authority • Completion certificates for at least 10 hours of CE in the past two years
over two years before this application but you do not hold prescriptive authority in another state	Submit completion certificates for at least 30 hours of CE in the past two years.

- Do not send documents such as copies of course registrations or letters/e-mails thanking you for registering as proof of CE.

OFFICE USE ONLY
DE RN _____
DE RN EXP _____
COMPACT _____
COMP LIC # _____
COMP LIC EXP _____
APN LIC # _____
JPC _____ **BOMP** _____
RX_____

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APPLICATION FOR LICENSURE AS AN ADVANCED PRACTICE NURSE

TYPE OF APPLICATION

1. Select type of **APN** application you are filing (check one):
   - ☐ I am applying for an *initial* license.
   - ☐ I am reinstating a *previously issued* Delaware license.

2. Are you also applying for an APN Temporary Permit at this time? Yes ☐ No ☐

> Delaware Temporary Permits are not valid for work in any other state. Temporary Permits do not include prescriptive authority. Before issuing a temporary permit, the Board office must receive the temporary license fee, official transcript, proof of certification or eligibility-to-test letter, and results of the criminal background check. If certification is not available for your specialty and you do not have the required 1000 hours practice in your specialty, the Board office must also receive a letter from your supervisor agreeing to supervise you and to report when you have completed the 1000-hour requirement.

3. Are you also applying for prescriptive authority at this time? Yes ☐ No ☐ Check yes *only if* you have a collaborative agreement.

4. Select the status of your Registered Nurse license (check one):
   - ☐ I am also applying for a Delaware RN at this time.
   - ☐ I already hold an active Delaware RN license. Enter license number: **L1-**_____
   - ☐ I hold an active RN license in _____. Enter license number: _____

5. Select the APN specialty for which you are applying (check one):
   - ☐ Certified Registered Nurse Anesthesist (CRNA)
   - ☐ Certified Nurse Midwife
   - ☐ Nurse Practitioner (NP) in this specialty area: _____
   - ☐ Certified Nurse Specialist (CNS) in this specialty area: _____

You must complete a separate application for each specialty for which you wish to be licensed.

IDENTIFYING AND CONTACT INFORMATION

6. Full Name: _____ (Last) _____ (First) _____ (Middle) _____ (Maiden)

7. Other Names Used: _____

8. Address: _____

_____ (City) _____ (State) _____ (Zip)

9. Enter your *State or Jurisdiction of Primary Residence*: _____ *Unless you are concurrently applying for a Delaware RN license*, **enclose a copy of your driver's license or an identification card issued by the Division of Motor Vehicles showing this state or jurisdiction as your residence.**

10. Phone: _____ _____ 11. Email: _____
daytime evening or cell

12. Date of Birth (month/day/year): _____

13. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
- If yes, enter your SSN: _____
- If no, you must file a *Request for Exemption from Social Security Number Requirement*.

EDUCATION

14. Enter the following information about the APN program you completed:

Program Name: _____
Address: _____

_____ _____ _____
City State/Country Zip/Postal Code

Entered Program (month/year): _____ Completed Program (month/year): _____

Degree Conferred: _____ Specialty Area: _____

Arrange for your program to send an official transcript *directly* to the Board office.

15. Enter the following information about *each* institution from which you hold a graduate degree.

COLLEGE/UNIVERSITY NAME	DATES ATTENDED	DEGREE

CERTIFICATION

16. Is national certification available for your specialty? Yes ☐ No ☐ If no, skip to DISCLOSURES section.

17. Have you been granted certification? Yes ☐ No ☐ If no, skip to Question 18.

CERTIFICATION INFORMATION

If you have certification, enter the following information. Then skip to the DISCLOSURES section.

National Certification Organization: _____

Certification Number: _____ Expiration Date: _____

Certification Granted by: Exam ☐ Waiver ☐

Has your national certification ever been suspended, revoked or otherwise disciplined? Yes ☐ No ☐ If yes, explain: _____
_____

Enclose copy of your current certification document. In addition…
- **If you are any specialty other than CRNA or Neonatal NP, arrange for the national certifying organization to complete the *Verification of National Certification* form and send it *directly* to the Board office.**
- **If you are a Neonatal NP, request verification online at** www.nccwebsite.org.
- **If you are a CRNA, only your certification document is required.**

18. Check the reason that you do not have certification:
☐ I am eligible for but have not yet taken the examination.
☐ I am not eligible to take the examination. Explain: _____
☐ I failed the examination. When? _____
☐ Other. Explain: _____

DISCLOSURES

19. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ If yes, explain below. Include any other name(s) used:
_____
_____
_____

20. Have you ever been declared judicially incompetent? Yes ☐ No ☐ If yes, explain: _____
_____

21. Are you now, or have you *ever* been, dependent on the use of alcohol, stimulants, or habit-forming drugs? Yes ☐ No ☐ If yes, explain: _____
_____

LICENSURE HISTORY – In this section, jurisdiction means State, District of Columbia, US territory or country.

22. Have you ever been denied Nursing licensure in Delaware or any other jurisdiction? Yes ☐ No ☐ If yes, where? _____ **Enclose a copy of the legal documents.**

23. Have you ***ever*** held an APN license *in any specialty* in *any state or jurisdiction*? Yes ☐ No ☐ If no, skip to the APN PRACTICE section.

APN LICENSE INFORMATION

If you have held an APN license anywhere enter the following information about *each* license you have held. Attach additional sheets if you need more room.

JURISDICTION (state, territory, or other country)	LICENSE NUMBER	EXPIRATION DATE

24. Have any of your Nursing licenses been surrendered, revoked, suspended, limited or placed on probation? Yes ☐ No ☐ If yes, If yes, where? _____ **Enclose a copy of the legal documents**.

25. Are any of your Nursing licenses currently under investigation? Yes ☐ No ☐ If yes, where? _____
_____ **Enclose a copy of the legal documents**.

APN PRACTICE

26. Have you practiced in the specialty for which you are applying? Yes ☐ No ☐ If no, skip to the COLLABORATIVE AGREEMENT section.

27. Check the one item that *best* describes your APN practice *in the specialty for which you are applying*:
    - ☐ I have practiced at least 1500 hours over the past five years or 600 hours in the past two years.
    - ☐ I have practiced at least 1000 hours over the past two years.
    - ☐ I graduated from my APN program within the past two years and I don't meet either of the practice requirements above.
    - ☐ None of the above describes my practice. **Attach a written explanation.**

28. Enter the following information about your practice in your specialty over the past *five years*. If you have not practiced in your specialty during the past five years, enter your most recent practice.

EMPLOYER	ADDRESS	EMPLOYMENT DATES	
		FROM	TO

COLLABORATIVE AGREEMENT

29. Do you have a collaborative agreement in Delaware? Yes ☐ No ☐ If yes, select the type of collaborative agreement you have and then skip to Question 31:
    - ☐ I have healthcare facility approved clinical privileges.
    - ☐ I have healthcare facility approved job description.
    - ☐ I have a written agreement with a physician, dentist, podiatrist, or licensed Delaware healthcare delivery system.

30. Do you understand that you are required to submit a *Collaborative Agreement Information* form about your collaborative agreement *before* you begin practicing as an APN in Delaware? Yes ☐ No ☐ Skip to the AFFIDAVIT section.

31. Do you agree to report to the Board office any changes in the person, facility or healthcare system with which you have a collaborative agreement? Yes ☐ No ☐

32. Enter the following information about your collaborator and then arrange for the appropriate signature in the Certification of Collaborator Agreement box:

    Name of Person/Facility/System: _____

    Address: _____

    _____ **DE** _____
    City Zip

    Phone: _____

CERTIFICATION OF COLLABORATOR AGREEMENT

IF the APN is applying for…	THEN the person signing this certification …
Both prescriptive authority and controlled substance registration	***must*** be DE-licensed physician, podiatrist or dentist.
Only prescriptive authority for non-controlled substances	*may* be either a designee of the health care system or a DE-licensed physician, podiatrist or dentist.

I certify that a process for consultation and referral of clients has been established with the APN named on this application for licensure. I understand that this agreement remains in place until either the APN or collaborating practitioner/health care system notifies the Delaware Board of Nursing in writing that the collaborative agreement is terminated.

Name of Person Certifying to the Collaborative Agreement: _____

Signature: _____ Date: _____

Delaware License No. _____

If Board review of your application is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date in order to assure consideration of your application at the meeting:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your permanent license (whether or not a temporary license has been issued).

AFFIDAVIT

The law regulating the practice of Nursing in Delaware, 24 *Del. C*. §1922 (a), "Grounds for Discipline," provides that the Board of Nursing may revoke or suspend any license to practice nursing, refuse a license or re-licensing or otherwise discipline a licensee upon proof that a licensee or former licensee is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing. The applicant, being duly sworn, says that he/she is the person referred to in the foregoing application for licensure as an advanced practical nurse in the State of Delaware, that he/she meets the requirements for licensure, that the statements therein contained are true and that he/she has read and understands this affidavit.

Applicant Signature: _____ Date: _____

Sworn to before me and subscribed in my presence this _____day of _____2____,
County of _____ State of _____

My commission expires: _____ _____
Notary Public

SEAL

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED PROCESSING FEE WILL BE REJECTED

Instructions for Requesting a Criminal Background Check

Criminal background checks, both federal and state, are required for all applicants for Nursing licensure. **You must complete this requirement *even if* you recently had a criminal background check done for some other reason.**

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 672-5319

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00 to cover both the State and Federal criminal checks. As fees are subject to change, contact the agency where you plan to submit your forms for current fees. Cash, money orders and credit cards other than American Express are accepted. *Personal checks are not accepted.*

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 672-5319** to request a fingerprint card.

2. Send your *Authorization for Release of Information* form, fingerprint card, and $69.00 fee (by personal check or money order) to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨ ***Allow four weeks for receipt of results.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OF NURSING OFFICE!!

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DELAWARE BOARD OF NURSING

AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL HISTORY RECORD CHECK

REASON FOR REQUEST: **Delaware Board of Nursing - License Application**

_____ _____ _____ _____
LAST NAME FIRST NAME MI SUFFIX

ALL OTHER NAMES USED IN THE PAST:

1. _____
2. _____
3. _____
4. _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO THE ADDRESS I HAVE DESIGNATED BELOW:

Name/Company: **Delaware Board of Nursing**

Address: **861 Silver Lake Boulevard, Suite 203**

City/State: **Dover, DE 19904**

ATTN: **D. Mangler**

AUTHORIZATION TO RELEASE INFORMATION:

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **DATE:** _____

Phone Number Home: _____ Work: _____

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

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VERIFICATION OF NATIONAL CERTIFICATION FOR ADVANCED PRACTICE NURSES

APPLICANT INFORMATION - to be completed by APN applicant
Send to the national certifying organization for your advanced practice specialty.

Name: _____ _____ _____ Social Security Number: _____
Last First Middle

Address:_____
Street

_____ _____ _____
City State Zip

Phone: _____ Email: _____

As an applicant for APN licensure in the State of Delaware, I authorize release of the requested information.

Applicant Signature: _____ Date: _____

CERTIFICATION – to be completed by national certifying organization
Return completed form *directly* to Board office address above.

Name of School/Program Applicant Attended: _____

Address:_____
Street

_____ _____ _____
City State Zip

Entered Program (month/year): _____ Completed (month/year): _____

Was school/program approved? Yes ☐ No ☐ If yes, by what certifying body? _____

Was program an external degree? Yes ☐ No ☐

Type of Program: Certificate ☐ Baccalaureate ☐ MSN ☐ 7**.** Area of Specialty: _____

Certification No.: _____ Effective Date: ☐ Exam _____ ☐ Waiver _____
Month/day/year Month/day/year

Certificate Status: ☐ Active/Current _____ ☐ Lapsed/Delinquent _____ ☐ Inactive/Non-Practicing
Month/day/year Month/day/year

Has any disciplinary action against this certificate been taken or has it ever been voluntarily surrendered? Yes ☐ No ☐
If yes, please explain on a separate sheet.

I certify that the information above is a true report for the nurse named above according to this agency's records.

Certifying Agency: _____

Name of Person Completing Form: _____ Title:_____

Signature: _____ Date:_____ SEAL